KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street, Rockville, Maryland 20849

2008 Summary of Benefits
HOWARD COUNTY GOVERNMENT
HMO SEL – Mid-Large Groups ($10/$20)
(Maryland)

The following is a limited description of benefits offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). Not all services and procedures are covered by your benefits contract. This Summary of Benefits is for comparison purposes only and does not create rights not given through the benefit plan.

PLAN DETAILS		
Copayments	$10 (PCP) / $20 (Specialty)	
Coinsurance (Plan pays / Member pays)	100% / 0% except as otherwise indicated	
Deductible	None	
Maximum Annual Copayment	Individual: $3,500	Family: $9,400
Lifetime Maximum	No lifetime maximum	

BENEFITS	**MEMBER PAYS**
OUTPATIENT SERVICES	
Preventive Health Office Visit	No charge
Preventive Health Screening Tests	No charge
Office Visit for Illness	
Primary Care Office Visit	$10 per visit (Copayment waived for children under age 5)
Specialty Care Office Visit	$20 per visit
Routine pre-natal visit (after confirmation of pregnancy) and first post-natal visit	No charge
Diagnostic Tests and Procedures, X-rays & Laboratory Services	No charge
Specialty Imaging (e.g., CT, MRI, PET scan & Nuclear Medicine)	No charge
Outpatient Surgery (other than in a provider's office)	$20 per procedure
HOSPITAL SERVICES	
Inpatient hospital care, including inpatient maternity care	No charge
Inpatient physician services	No charge
CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES	
Inpatient hospital care	No charge
Outpatient services	$20 per visit for individual therapy; $10 per visit for group therapy
THERAPY & REHABILITATION SERVICES	
Inpatient hospital care	No charge
Outpatient services	$20 per visit
INFERTILITY SERVICES	
Office visits	50% of allowable charge
All other covered services for treatment of infertility (In vitro fertilization benefit limited to 3 attempts per live birth and a lifetime maximum Health Plan benefit of $100,000)	50% of allowable charge
URGENT CARE & EMERGENCY SERVICES	
Urgent Care Office Visit	$10 per visit (PCP) / $20 per visit (Specialty)
After hours Urgent Care or Urgent Care Center	$20 per visit
Hospital Emergency Room (waived if admitted as inpatient)	$25 per visit
Ambulance	No charge
HOSPITAL ALTERNATIVES	
Skilled Nursing Facility (limited to 100 days per contract year)	No charge
Home Health Care	No charge
Hospice Care	No charge
OTHER SERVICES	
Durable Medical Equipment (DME)	
Basic DME	No charge
Oxygen equipment	No charge for 1st 3 months then 50% of allowable charge thereafter
Prosthetics	
Internal prosthetics	No charge
External prosthetics	No charge

BENEFITS	MEMBER PAYS
Vision	
Office visit for medical conditions of the eye	$10 per visit (PCP) / $20 per visit (Specialty)
Routine eye refractions to determine need for vision correction	$10 per visit with Optometrist $20 per visit with Ophthalmologist (referral required)
Eyeglass frames and lenses (limited to one pair of glasses per contract year)	Member receives 25% discount from Plan Providers
Contact lenses	Member receives 15% discount on initial pair of contact lenses only
Prescription Drugs	
Covered prescription drugs (up to a 60-day supply, includes Viagra)	**Plan Pharmacy & Mail Order –** $10 Generic / $20 Brand **Participating Network Pharmacy –** $16 Generic / $32 Brand

RIDERED BENEFITS	MEMBER PAYS
Complementary Alternative Medicine	
Chiropractic Services (Limited to 20 visits per contract year)	$15 per visit
Acupuncture Services (Limited to 20 visits per contract year)	$15 per visit
Hearing Aids	
Hearing Tests	$20 per visit
Hearing aids for children under age 18 (Health Plans pays up to a benefit maximum of $1,400 per hearing aid for each hearing-impaired ear every 36 months.)	No charge up to Health Plan maximum payment
Hearing aids for Members age 18 and older (Health Plans pays up to a benefit maximum of $1,400 per hearing aid for each hearing-impaired ear every 36 months.)	No charge up to Health Plan maximum payment

This Benefit and Service Summary does not fully describe the exclusions and limitations associated with your Kaiser Permanente coverage. For a full list of the general and benefit specific exclusions under your coverage, please refer to your KFHP-MAS Evidence of Coverage (EOC). Your EOC provides you with information on what services and supplies will not be covered, regardless of whether the service is medically necessary.

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Form Numbers: MDLG-ALL-SEC1(1/06); MDLG-ALL-SEC2(1/07); MDLG-ALL-SEC3 (1/06); MDLG-ALL-SEC4 (1/06); MDLG-ALL-SEC5(05/04); MDLG-ALL-SEC6(1/04); MDLG-ALL-SEC7(1/06); MDLG-ALL-APPX-DEF (1/06); MDLG-HMO-COST(1/06); and any amendments or riders attached thereto.